

**DEPARTMENT OF HEALTH SERVICES**

14744 P Street  
Box 942732  
Sacramento, CA 94234-7320  
(916) 657-2941

October 22, 1998



TO: All County Welfare Directors  
All County Administrative Officers  
All County Medi-Cal Program Specialists/Liaisons  
All County Public Health Directors

Letter No.: 98-46

**ENHANCED FUNDING FOR THE PROPERTY DISREGARD PORTION OF THE PERCENT PROGRAMS**

Ref.: All County Welfare Directors Letters No. 98-16 and 98-39

The purpose of this letter is to inform counties that cases that contain children/persons in the 100 and 133 Percent programs which have or appear to have excess property are to be reported to the Medi-Cal Eligibility Data System on December 1, 1998. Counties were previously asked to begin flagging those cases on July 10, 1998 (E-Mail No. 98096).

The Department of Health Services will claim enhanced federal funding for the expansion of the property disregard program. These aid codes are:

- 8N 133 Percent program children with excess property - emergency benefits only
- 8P 133 Percent program children with excess property - full-scope benefits
- 8T 100 Percent program children with excess property - emergency/pregnancy only
- 8R 100 Percent program children with excess property - full-scope benefits

These aid codes will be used for children in the 100 and 133 Percent programs when the county has determined that the child or the family has excess property because:

- The county has determined that the child would have been denied or discontinued due to excess property, or
- Either of the questions in the box at the bottom of Page 20 of the mail-in application (a copy of which is enclosed) "Do you have more than one car?", or "Do you have more than \$3,150 cash in bank accounts?" have been positively responded to.

These aid codes will have similar edits and messages as used for the 133 Percent aid codes (72 and 74) and the 100 Percent aid codes (7A and 7C).

Counties must identify and track all aliens who receive benefits under any of these new aid codes (see ACWDL 97-42).

We are not requiring counties to identify pregnant women or infants with excess property or who may have excess property since enhanced funding is not available for these persons.

All County Welfare Directors  
All County Administrative Officers  
All County Medi-Cal Program Specialists/Liaisons  
All County Public Health Directors  
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If you have any further questions, please contact Ms. Marge Buzdas of my staff at  
(916) 657-0726.

Sincerely,

ORIGINAL SIGNED BY

Enclosure - - -

Glenda Arellano  
Angeline Mrva, Chief  
Medi-Cal Eligibility Branch

# Part C: Application for the Medi-Cal Program (continued)

## SECTION 4: Certification Of Applicant—Applicant Must Read And Initial Each Statement

1. I have read and received a copy of the Important Information for Persons Requesting Medi-Cal (MC 219) on pages 24-27.
2. I understand that all of the statements here, including benefits and income information, that I have made on this form and all supplemental forms are subject to investigation and verification.
3. I declare, to the best of my knowledge and belief that the information I have provided in this application and its supplemental form(s) is true and correct.
4. I understand that the county is required by law to keep any information I provide confidential.
5. I understand that information I give may be shared with state and local agencies involved in the administration of health programs.

## SECTION 5: Signatures

1. Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_\_  
1a. Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
  2. Signature of Person acting for Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
2a. Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
  3. Signature of Witness: (if applicant signed with a mark) \_\_\_\_\_ Date: \_\_\_\_\_  
3a. Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
  4. Signature of Person helping Applicant fill out the form: \_\_\_\_\_ Date: \_\_\_\_\_  
4a. Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
- I declare under penalty of perjury under the laws of the State of California that the answers I have given are correct and true to the best of my knowledge.
- 5. APPLICANT SIGNATURE X \_\_\_\_\_ Date: \_\_\_\_\_

You must send additional forms and copies of proof with your Medi-Cal application.  
See page 23 for acceptable examples of verification and mailing instruction.

Answers to the questions in this box will give us information that will make it possible for the federal government to help California pay for its health care programs.  
Your answers will not affect your eligibility.

- |  |                             |                              |
|--|-----------------------------|------------------------------|
| Do you have more than one car?                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have more than \$3,150 cash in bank accounts? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |